



Facility Name & ID Number Evergreen Healthcare Center

# 0044560 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>242</u>	Skilled (SNF)	<u>242</u>	<u>88,572</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>242</u>	TOTALS	<u>242</u>	<u>88,572</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>22,825</u>	<u>16,961</u>	<u>29,828</u>	<u>69,614</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>22,825</u>	<u>16,961</u>	<u>29,828</u>	<u>69,614</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.60%

D. How many bed-hold days during this year were paid by Public Aid?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 11/30/99

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 11/30/99 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number of beds certified 242 and days of care provided 25,348

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/04 Fiscal Year: 12/31/04

\* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number      Evergreen Healthcare Center      #      0044560      Report Period Beginning:      01/01/04      Ending:      12/31/04

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	415,719	59,528	685	475,932		475,932	9,776	485,708			1
2	Food Purchase		382,341		382,341		382,341	(3,808)	378,533			2
3	Housekeeping		23,259	279,267	302,526		302,526		302,526			3
4	Laundry			186,946	186,946		186,946		186,946			4
5	Heat and Other Utilities			258,994	258,994		258,994	5,207	264,201			5
6	Maintenance	125,239	6,415	188,613	320,267		320,267	(19,690)	300,577			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	540,958	471,543	914,505	1,927,006		1,927,006	(8,515)	1,918,491			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			37,118	37,118		37,118		37,118			9
10	Nursing and Medical Records	5,477,808	384,142	116,953	5,978,903		5,978,903	62,771	6,041,674			10
10a	Therapy		169	14,782	14,951		14,951	(403)	14,548			10a
11	Activities	137,217	24,479	2,201	163,897		163,897		163,897			11
12	Social Services	275,929	47	861	276,837		276,837		276,837			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	5,890,954	408,837	171,915	6,471,706		6,471,706	62,368	6,534,074			16
	<b>C. General Administration</b>											
17	Administrative	53,685		1,071,453	1,125,138		1,125,138	(403,182)	721,956			17
18	Directors Fees											18
19	Professional Services			104,569	104,569		104,569	(2,987)	101,582			19
20	Dues, Fees, Subscriptions & Promotions			94,073	94,073		94,073	(4,623)	89,450			20
21	Clerical & General Office Expenses	309,471	58,330	1,075,394	1,443,195		1,443,195	(942,827)	500,368			21
22	Employee Benefits & Payroll Taxes			1,302,355	1,302,355		1,302,355		1,302,355			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,939	6,939		6,939		6,939			24
25	Other Admin. Staff Transportation			18,013	18,013		18,013	(13,944)	4,069			25
26	Insurance-Prop.Liab.Malpractice			534,708	534,708		534,708		534,708			26
27	Other (specify):*							109,236	109,236			27
28	<b>TOTAL General Administration</b>	363,156	58,330	4,207,504	4,628,990		4,628,990	(1,258,327)	3,370,663			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	6,795,068	938,710	5,293,924	13,027,702		13,027,702	(1,204,474)	11,823,228			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			150,416	150,416		150,416	466,841	617,257			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			476	476		476	871,053	871,529			32
33	Real Estate Taxes			480,000	480,000		480,000		480,000			33
34	Rent-Facility & Grounds			1,043,753	1,043,753		1,043,753	(986,209)	57,544			34
35	Rent-Equipment & Vehicles			32,585	32,585		32,585	6,595	39,180			35
36	Other (specify):*											36
37	TOTAL Ownership			1,707,230	1,707,230		1,707,230	358,280	2,065,510			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,572,144	2,264,246	3,836,390		3,836,390	(61,679)	3,774,711			39
40	Barber and Beauty Shops	5,268			5,268		5,268	(5,268)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			132,858	132,858		132,858		132,858			42
43	Other (specify):*	36,595		59,406	96,001		96,001	(96,001)				43
44	TOTAL Special Cost Centers	41,863	1,572,144	2,456,510	4,070,517		4,070,517	(162,948)	3,907,569			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,836,931	2,510,854	9,457,664	18,805,449		18,805,449	(1,009,141)	17,796,308			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.  
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(2,392)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	16,681	30		9
10	Interest and Other Investment Income	(12,341)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(931)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(13,944)	25		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(934,858)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(140,015)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,087,799)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	78,658		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 78,658		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ (1,009,141)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.  
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

ID#

0044560

Report Period Beginning:

01/01/04

Ending:

12/31/04

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Bank Fees	\$ (4,843)	21	1
2	COPE Dues	(4,623)	20	2
3	Misc Income - Various	(734)	21	3
4	Misc Income - Medical Record Fees	(195)	10	4
5	Misc Income - Donations for Haircuts	(65)	40	5
6	Misc Income - Meals	(2,877)	02	6
7	Misc Income - Electric	(208)	05	7
8	Misc Income - Jury Duty	(67)	10	8
9	Marketing Expenses	(96,001)	43	9
10	Legal Fees	(2,987)	19	10
11	Capitalized R&M	(20,894)	6	11
12	Barber & Beauty	(5,203)	40	12
13	Private Duty Wages	(1,318)	10	13
14				14
15				15
16				16
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97				97
98				98
99				99
100				100
101	Total	(140,015)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/04 Ending: 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary			9,776									9,776	1
2	Food Purchase	(3,808)											(3,808)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(208)		5,415									5,207	5
6	Maintenance	(20,894)		1,204									(19,690)	6
7	Other (specify):*													7
8	TOTAL General Services	(24,910)		16,395									(8,515)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(1,580)		64,351									62,771	10
10a	Therapy				(403)								(403)	10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(1,580)		64,351	(403)								62,368	16
	C. General Administration													
17	Administrative			(403,182)									(403,182)	17
18	Directors Fees													18
19	Professional Services	(2,987)											(2,987)	19
20	Fees, Subscriptions & Promotions	(4,623)											(4,623)	20
21	Clerical & General Office Expenses	(942,827)											(942,827)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation	(13,944)											(13,944)	25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*			109,236									109,236	27
28	TOTAL General Administration	(964,381)		(293,946)									(1,258,327)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(990,871)		(213,200)	(403)								(1,204,474)	29



## Summary B

12/31/04

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Evergreen Healthcare Realty	100%	See Attached		See Attached		
see attached list of Evergreen HC Realty owners						
				Evergreen Healthcare Realty, llc		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 1,038,000	Evergreen Healthcare Realty, LLC		\$	\$ (1,038,000)	1
2	V	32	Interest Income	3,117	Evergreen Healthcare Realty, LLC			(3,117)	2
3	V	30	Depreciation		Evergreen Healthcare Realty, LLC		420,187	420,187	3
4	V	32	Interest Expense		Evergreen Healthcare Realty, LLC		883,849	883,849	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,041,117			\$ 1,304,036	\$ * 262,919	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ X

 YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Management Fees	\$ 1,071,453	Boulevard Healthcare Management, LLC	100.00%	\$	\$ (1,071,453)	15
16	V	5	Utilities		Boulevard Healthcare Management, LLC	100.00%	5,415	5,415	16
17	V	10	Nursing & Rehabilitation		Boulevard Healthcare Management, LLC	100.00%	64,351	64,351	17
18	V	15	Payroll Taxes, Fringes, Staff Dev.		Boulevard Healthcare Management, LLC	100.00%			18
19	V	1	Dietary Expenses		Boulevard Healthcare Management, LLC	100.00%	9,776	9,776	19
20	V	17	Administrative & General		Boulevard Healthcare Management, LLC	100.00%	668,271	668,271	20
21	V	6	Maint. & Minor Equipment		Boulevard Healthcare Management, LLC	100.00%	1,204	1,204	21
22	V	27	Payroll Taxes, Fringes, Staff Dev.		Boulevard Healthcare Management, LLC	100.00%	109,236	109,236	22
23	V	30	Depreciation		Boulevard Healthcare Management, LLC	100.00%	29,973	29,973	23
24	V	34	Lease & Rent - Building		Boulevard Healthcare Management, LLC	100.00%	51,791	51,791	24
25	V	35	Lease & Rent - Equipment		Boulevard Healthcare Management, LLC	100.00%	6,595	6,595	25
26	V	32	Interest Expense		Boulevard Healthcare Management, LLC	100.00%	2,662	2,662	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 1,071,453			\$ 949,274	\$ * (122,179)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	REHAB CONSULTING	\$ 14,782	ADVANCED THERAPY & REHAB, LLC	100.00%	\$ 14,379	\$ (403)	15
16	V	39	ANCILLARY REHAB	2,259,309	ADVANCED THERAPY & REHAB, LLC	100.00%	2,197,630	(61,679)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 2,274,091			\$ 2,212,009	\$ * (62,082)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT



VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/04 Ending: 12/31/04

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Fred Benjamin	Administrative	Administrative	1.45%	see attached	10.05	18.27%	Alloc-Blvd	\$ 33,778	17-7	1
2	Judy Dabertin	COO	Administrative	0.07%	see attached	5.50	19.39%	Alloc-Blvd	31,645	17-7	2
3	Jeff Elowe	Administrative	Administrative	10.61%	see attached	3.17	11.19%	Alloc-Blvd	26,063	17-7	3
4	Sherri Noon	Administrative	Administrative	0.06%	see attached	11.17	22.34%	Alloc-Blvd	25,021	17-7	4
5	Steve VanCamp	Administrative	Administrative	0.29%	see attached	11.17	22.34%	Alloc-Blvd	31,354	17-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 147,861		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number      Evergreen Healthcare Center      #      0044560      Report Period Beginning:      01/01/04      Ending:      12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)      YES ☐      NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

( )

( )

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number      Evergreen Healthcare Center      #      0044560      Report Period Beginning:      01/01/04      Ending:      12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)      YES ☒      NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization      Boulevard Healthcare Management, LLc  
Street Address      8950 Gross Point Road, Suite 600  
City / State / Zip Code      Skokie, IL 60077  
Phone Number      ( 847) 663-1155  
Fax Number      ( 847) 663-0917

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	5	Utilities	Patient Days/Direct	289,568	6	25,313	\$	Direct	\$ 5,415	1
2	10	Nursing & Rehabilitation	Patient Days/Direct	289,568	6	300,816		Direct	64,351	2
3	15	Payroll Taxes, Fringes, Staff Dev.	Patient Days/Direct	289,568	6	49,368		Direct		3
4	1	Dietary Expenses	Patient Days/Direct	289,568	6	53,197		Direct	9,776	4
5	17	Administrative & General	Patient Days/Direct	289,568	6	2,972,648		Direct	668,271	5
6	6	Maint. & Minor Equipment	Patient Days/Direct	289,568	6	5,628		Direct	1,204	6
7	27	Payroll Taxes, Fringes, Staff Dev.	Patient Days/Direct	289,568	6	417,384		Direct	109,236	7
8	30	Depreciation	Patient Days/Direct	289,568	6	140,111		Direct	29,973	8
9	34	Lease & Rent - Building	Patient Days/Direct	289,568	6	190,312		Direct	51,791	9
10	35	Lease & Rent - Equipment	Patient Days/Direct	289,568	6	24,234		Direct	6,595	10
11	32	Interest Expense	Patient Days/Direct	289,568	6	9,783		Direct	2,662	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 4,188,794	\$ 2,262,157		\$ 949,274	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number      Evergreen Healthcare Center      #      0044560      Report Period Beginning:      01/01/04      Ending:      12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)      YES ☒      NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization      ADVANCED THERAPY AND REHAB, LLC  
Street Address      8950 GROSS POINT RD. #E  
City / State / Zip Code      SKOKIE, IL 60077  
Phone Number      ( 847)663-1155  
Fax Number      ( 847)663-0917

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10A	REHAB CONSULTING	DIRECT ALLOCATION						14,379	1
2	39	ANCILLARY REHAB	DIRECT ALLOCATION						2,197,630	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		2,212,009	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number      Evergreen Healthcare Center      #    0044560    Report Period Beginning:      01/01/04      Ending:    12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)      YES ☐      NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

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	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_  
Street Address \_\_\_\_\_  
City / State / Zip Code \_\_\_\_\_  
Phone Number (\_\_\_\_) \_\_\_\_\_  
Fax Number (\_\_\_\_) \_\_\_\_\_

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number      Evergreen Healthcare Center      #      0044560      Report Period Beginning:      01/01/04      Ending:      12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)      YES ☐      NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

( )

( )

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number      Evergreen Healthcare Center      #      0044560      Report Period Beginning:      01/01/04      Ending:      12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)      YES ☐      NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

( )

( )

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number      Evergreen Healthcare Center      #    0044560    Report Period Beginning:      01/01/04      Ending:    12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)      YES ☐      NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

( )

( )

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number      Evergreen Healthcare Center      #      0044560      Report Period Beginning:      01/01/04      Ending:      12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)      YES ☐      NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

( )

( )

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number      Evergreen Healthcare Center      #    0044560    Report Period Beginning:      01/01/04      Ending:    12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)      YES ☐      NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_  
Street Address \_\_\_\_\_  
City / State / Zip Code \_\_\_\_\_  
Phone Number (    ) \_\_\_\_\_  
Fax Number (    ) \_\_\_\_\_

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10			
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense				
		YES	NO				Original	Balance							
	A. Directly Facility Related														
	Long-Term														
1	DeLage Landen		X	Equipment Financing			\$				\$	256	1		
2	LaSalle Bank		X	Mortgage					11,641,202			879,205	2		
3													3		
4													4		
5	See Supplemental Schedule												5		
	Working Capital														
6	LaSalle Bank		X	Working Capital								220	6		
7	Allocation from Boulevard		X									2,662	7		
8	See Supplemental Schedule								550,000			4,644	8		
9	TOTAL Facility Related						\$		\$	12,191,202			\$	886,987	9
	B. Non-Facility Related*														
10	Interest Income		X									(12,341)	10		
11	Interest Income (Bldg Co)		X									(3,117)	11		
12													12		
13	See Supplemental Schedule												13		
14	TOTAL Non-Facility Related						\$		\$				\$	(15,458)	14
15	TOTALS (line 9+line14)						\$		\$	12,191,202			\$	871,529	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related Long-Term																		
1							\$					\$							1
2																			2
3																			3
4																			4
5																			5
6																			6
7	TOTAL Long-Term																		7
	Working Capital																		
8	LaSalle Bank		X	Line of Credit			\$		\$	550,000					\$	4,644			8
9																			9
10																			10
11																			11
12																			12
13																			13
14	TOTAL Working Capital									550,000						4,644			14
	B. Non-Facility Related*																		
15							\$		\$						\$				15
16																			16
17																			17
18																			18
19																			19
20	TOTAL Non-Facility Related																		20

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT



## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

## B. Real Estate Taxes

			<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1.	Real Estate Tax accrual used on 2003 report.	\$	<b>1,897,500</b>	<b>1</b>	
2.	Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$		<b>2</b>	
3.	Under or (over) accrual (line 2 minus line 1).	\$	(1,897,500)	<b>3</b>	
4.	Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<b>2,377,500</b>	<b>4</b>	
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$		<b>5</b>	
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. <b>(Attach a copy of the real estate tax appeal board's decision.)</b>	\$		<b>6</b>	
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	<b>480,000</b>	<b>7</b>	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1999		<b>8</b>	
		2000		<b>9</b>	
		2001		<b>10</b>	
		2002		<b>11</b>	
		2003		<b>12</b>	
<b>Property purchased from Not for Profit. Tax bills not received yet.</b>					
<b>Accrual is based on Real Estate Tax Estimate.</b>					

	<b>FOR OHF USE ONLY</b>		
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2003      \$		<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5                  \$		<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6                        \$		<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION \$		<b>16</b>

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed**

**SEE ACCOUNTANTS' COMPILATION REPORT**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Evergreen Healthcare Center

COUNTY

Cook

FACILITY IDPH LICENSE NUMBER

0044560

CONTACT PERSON REGARDING THIS REPORT

Steve Lavenda

TELEPHONE

(847)236-1111

FAX #:

(847)236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Evergreen Healthcare Center

COUNTY

Cook

FACILITY IDPH LICENSE NUMBER

0044560

CONTACT PERSON REGARDING THIS REPORT

Steve Lavenda

TELEPHONE

(847)236-1111

FAX #:

(847)236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 82,212

B. General Construction Type: Exterior Brick Frame Basement Foundation Number of Stories 1

C. Does the Operating Entity? ☐ (a) Own the Facility ☒ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☒ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.					
	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Facility</u>		<u>1999</u>	<u>\$ 1,627,500</u>	1
2					2
3	TOTALS			\$ 1,627,500	3

SEE ACCOUNTANTS' COMPILATION REPORT

11/3/2005 8:51 AM

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1999		3,440		20	172	172	688	9
10	Various		2000		18,650		20	934	934	3,733	10
11								-		-	11
12								-		-	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		7,959,539	201,707		238,119	36,412	1,181,282	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		3,983	797		797		2,063	68
69	Financial Statement Depreciation			7,523			(7,523)		69
70	TOTAL (lines 4 thru 69)		\$ 7,985,612	\$ 210,027		\$ 240,022	\$ 29,995	\$ 1,187,766	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name &amp; ID Number    Evergreen Healthcare Center

#    0044560

Report Period Beginning:

01/01/04

Ending:

12/31/04

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 7,985,612	\$ 210,027		\$ 240,022	\$ 29,995	\$ 1,187,766	1
2	Concrete Work	2001	6,000		20	300	300	1,075	2
3	Carpet	2001	2,100		20	105	105	359	3
4	Water Heater	2001	5,456		20	273	273	886	4
5	Compressor Repair	2001	7,229		20	361	361	1,325	5
6	Conduits	2001	3,550		20	178	178	667	6
7	Filters	2001	535		20	27	27	100	7
8	Ventillation Dompers	2001	900		20	45	45	169	8
9	Concrete	2001	2,200		20	110	110	413	9
10	Freezer Piping	2001	2,460		20	123	123	472	10
11	Filters	2001	545		20	27	27	98	11
12	Filters	2001	840		20	42	42	147	12
13	Refrigeration Repair	2001	574		20	29	29	113	13
14	Hydroguard	2001	613		20	31	31	97	14
15	Hydraulic Gas Valve	2001	1,050		20	53	53	162	15
16	Wallpaper	2001	941		20	47	47	176	16
17	Cubicle Curtains	2002	5,670		20	567	567	1,607	17
18	Replacement Blinds	2002	2,593		20	259	259	713	18
19	Nurse Call/ Pocket Page System	2002	1,280		20	128	128	352	19
20	Tv Hook Ups	2002	7,500		20	750	750	2,000	20
21	Transmitter Bands	2002	587		20	59	59	147	21
22	Cabling Facility	2002	15,002		20	1,500	1,500	4,376	22
23	Replace Frequency Drive	2002	2,900		20	290	290	798	23
24	Security System On Exits	2002	2,387		20	239	239	637	24
25	Security System On Exits	2002			20				25
26	Repair Fire Sprinkler	2002	2,390		20	239	239	637	26
27	Replace Condenser	2002	1,050		20	105	105	271	27
28	Convert Duplex To Quads	2002	28,300		20	2,830	2,830	7,311	28
29	Replace Damper Motor	2002	1,058		20	106	106	247	29
30	Wall & Chimney Work	2002	4,240		20	424	424	989	30
31	Replace Damper Motor	2002	1,013		20	101	101	228	31
32	Heat Exchanger	2002	797		20	80	80	173	32
33	Heat Exchanger	2002	525		20	53	53	114	33
34	TOTAL (lines 1 thru 33)		\$ 8,097,897	\$ 210,027		\$ 249,503	\$ 39,476	\$ 1,214,625	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 8,097,897	\$ 210,027		\$ 249,503	\$ 39,476	\$ 1,214,625	1
2	Heat Exchanger	2002	104		20	10	10	22	2
3	Heat Exchanger	2002	393		20	39	39	82	3
4	Heat Exchanger	2002	3,475		20	348	348	724	4
5	Heat Exchanger	2002	1,775		20	178	178	370	5
6	Heat Exchanger	2002	600		20	60	60	125	6
7	Replace Compressors	2002	4,330		20	433	433	1,119	7
8	Locks	2002	513		20	41	41	111	8
9	Exhaust Fan	2002	564		20	56	56	150	9
10	Air Temp Sensor	2002	1,002		20	100	100	267	10
11	Counter Top	2002	575		20	58	58	149	11
12	Paint & Wallpaper	2002	550		20	55	55	142	12
13	Repairs	2002	880		20	88	88	220	13
14	Black Box	2002	635		20	64	64	159	14
15	Vent Repair	2002	1,450		20	145	145	350	15
16	Cord For Security Tv	2002	597		20	60	60	139	16
17	Mini-Blinds	2002	543		20	54	54	158	17
18	Floor Patch	2002	500		20	50	50	133	18
19	Carpeting	2003	1,755		20	176	176	351	19
20	Centrifugal Vent	2003	676		20	68	68	124	20
21	Telephone Equipment	2003	129,400		20	12,940	12,940	21,567	21
22	Vertical Blinds	2003	630		20	63	63	116	22
23	Counter Top	2003	1,067		20	107	107	169	23
24	Tree & Shrubs	2003	19,230		20	3,846	3,846	6,090	24
25	Air Conditioner	2003	2,132		20	426	426	604	25
26	Replace Pipes	2003	968		20	97	97	186	26
27	Data Drop Lines	2003	2,626		20	263	263	481	27
28	Duct Work Hvac	2003	1,717		20	172	172	315	28
29	Hvac	2003	1,608		20	161	161	295	29
30	Replace Doors	2003	1,996		20	200	200	333	30
31	Replace Doors	2003	2,982		20	298	298	497	31
32	Hvac	2003	1,199		20	120	120	210	32
33	Hvac	2003	1,327		20	133	133	232	33
34	TOTAL (lines 1 thru 33)		\$ 8,285,696	\$ 210,027		\$ 270,412	\$ 60,385	\$ 1,250,615	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.



## XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 8,285,696	\$ 210,027		\$ 270,412	\$ 60,385	\$ 1,250,615	1
2	Hvac	2003	3,915		20	392	392	653	2
3	Hvac	2003	3,350		20	335	335	558	3
4	Hvac	2003	1,183		20	118	118	197	4
5	Replace Doors	2003	3,573		20	357	357	566	5
6	Hvac	2003	3,550		20	355	355	562	6
7	Hvac	2003	834		20	83	83	132	7
8	Hvac	2003	669		20	67	67	100	8
9	Hvac	2003	710		20	71	71	107	9
10	Electrical	2003	750		20	75	75	106	10
11	Install Counter	2003	853		20	85	85	121	11
12	Water Heater Piping	2003	5,950		20	595	595	843	12
13	Hvac	2003	3,475		20	348	348	492	13
14	Oak Door	2003	1,560		20	156	156	195	14
15	Oak Doors	2003	3,040		20	304	304	380	15
16	Computer Datalines	2003	17,083		20	2,440	2,440	3,254	16
17	Electric Recepticles	2003	750		20	75	75	106	17
18	Computer Data Lines	2003	2,746		20	275	275	343	18
19	Nurse Call System	2003	1,424		20	142	142	285	19
20	Roof Repair	2003	2,709		20	271	271	519	20
21	Fire System Repair	2003	697		20	70	70	122	21
22	Roof Repair	2003	5,500		20	550	550	871	22
23	Storeroom Locks	2003	650		20	65	65	103	23
24	Phone System Repair	2003	1,394		20	139	139	209	24
25	Electronic Locks	2003	508		20	51	51	76	25
26	Roof Repair	2003	742		20	74	74	99	26
27	Fire System Repair	2003	700		20	70	70	111	27
28	Phone System Repair	2003	1,581		20	158	158	171	28
29	Bwd Roof/Evg Wall Cove *	2004	27,500		20	458	458	458	29
30	Replace Door	2004	1,495		20	150	150	150	30
31	Hot Water System Thermal Control *	2004	2,613		20	44	44	44	31
32	Hot Water System Valve *	2004	819		20	14	14	14	32
33	Painting *	2004	900		20	45	45	45	33
34	TOTAL (lines 1 thru 33)		\$ 8,388,919	\$ 210,027		\$ 278,844	\$ 68,817	\$ 1,262,607	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 8,388,919	\$ 210,027		\$ 278,844	\$ 68,817	\$ 1,262,607	1
2	Heating / Cooling *	2004	878		20	40	40	40	2
3	Heating / Cooling *	2004	866		20	36	36	36	3
4	Drain Rebuilding Kit *	2004	545		20	23	23	23	4
5	Handrails *	2004	1,175		20	49	49	49	5
6	Gas Valve Repair *	2004	691		20	26	26	26	6
7	Heating / Cooling *	2004	876		20	33	33	33	7
8	Relay Base - Dampers *	2004	532		20	20	20	20	8
9	Heating / Cooling *	2004	1,745		20	65	65	65	9
10	Repair Garage Door *	2004	513		20	17	17	17	10
11	Fire Alarm Panel Repair *	2004	550		20	11	11	11	11
12	Replace Parking Lot Light *	2004	1,685		20	28	28	28	12
13	Matv System Service *	2004	685		20	11	11	11	13
14	Heating Unit Repair *	2004	900		20	4	4	4	14
15	* Added After 6/30/04 Capital Report								15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,400,560	\$ 210,027		\$ 279,207	\$ 69,180	\$ 1,262,970	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 8,400,560	\$ 210,027		\$ 279,207	\$ 69,180	\$ 1,262,970	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,400,560	\$ 210,027		\$ 279,207	\$ 69,180	\$ 1,262,970	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 8,400,560	\$ 210,027		\$ 279,207	\$ 69,180	\$ 1,262,970	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,400,560	\$ 210,027		\$ 279,207	\$ 69,180	\$ 1,262,970	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 8,400,560	\$ 210,027		\$ 279,207	\$ 69,180	\$ 1,262,970	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,400,560	\$ 210,027		\$ 279,207	\$ 69,180	\$ 1,262,970	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 8,400,560	\$ 210,027		\$ 279,207	\$ 69,180	\$ 1,262,970	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,400,560	\$ 210,027		\$ 279,207	\$ 69,180	\$ 1,262,970	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 8,400,560	\$ 210,027		\$ 279,207	\$ 69,180	\$ 1,262,970	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,400,560	\$ 210,027		\$ 279,207	\$ 69,180	\$ 1,262,970	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 8,400,560	\$ 210,027		\$ 279,207	\$ 69,180	\$ 1,262,970	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,400,560	\$ 210,027		\$ 279,207	\$ 69,180	\$ 1,262,970	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.



XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	242		1999		\$ 7,052,500	\$ 188,367	35	\$ 201,500	\$ 13,133	\$ 1,024,292	4
5			1999		303,742		35	8,678	8,678	44,113	5
6			2000		103,836		35	2,967	2,967	14,835	6
7											7
8											8
	Improvement Type**										
9	Duct Work		2000		90,000		20	4,500	4,500	18,375	9
10	Masonry Restorater		2000		131,234		20	6,562	6,562	27,342	10
11	Permit Fees		2000		5,165		20	258	258	1,075	11
12	Parking Lot		2000		108,000		20	5,400	5,400	22,500	12
13	Parking Lot - Engineer		2000		2,500		20	125	125	531	13
14	Architect Fees		2000		11,619		20	581	581	2,518	14
15	Survey Fees		2000		2,000		20	100	100	417	15
16	General Contract Fees		2000		25,356		20	1,268	1,268	5,176	16
17	General Contract Fees		2001		3,538		20	177	177	384	17
18	Architect Fees		2001		3,097		20	155	155	542	18
19	Landscaping		2001		27,435		20	1,372	1,372	4,802	19
20	Parking Lot		2001		50,000		20	2,500	2,500	8,334	20
21	Curb Replacement		2001		2,200		20	110	110	386	21
22	Roof Repair		2001		2,200		20	110	110	366	22
23	Bathroom		2001		2,250		20	113	113	376	23
24	Tile Work		2001		500		20	25	25	80	24
25	Kitchen Work		2001		3,900		20	195	195	618	25
26	Vending Area Work		2001		1,900		20	95	95	300	26
27	Kitchen Work		2001		1,084		20	54	54	172	27
28	A/C Units		2001		4,884		20	244	244	772	28
29	Sheet Metal System		2001		9,540		20	477	477	1,432	29
30	Architect Fees		2001		4,579		20	229	229	572	30
31	Architect Fees		2002		6,480		20	324	324	972	31
32						13,340			(13,340)		32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 7,959,539	\$ 201,707		\$ 238,119	\$ 36,412	\$ 1,181,282	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$		4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocated from Boulevard Healthcare			2002	3,983	797	5	797		2,063	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,983	\$ 797		\$ 797	\$	\$ 2,063	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 2,939,025	\$ 353,078	\$ 332,390	\$ (20,688)	10	\$ 1,376,988	71
72	Current Year Purchases	67,383	37,471	5,660	(31,811)	10	5,660	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 3,006,408	\$ 390,549	\$ 338,050	\$ (52,499)		\$ 1,382,648	75

D. Vehicle Depreciation (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

E. Summary of Care-Related Assets					1	2
		Reference			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$	13,034,469
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	600,576
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	617,257
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	16,681
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	2,645,618

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)				
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
86		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Storage Rental				5,753			5
6	Allocated from Boulevard HC Mgmt				51,791			6
7	TOTAL				\$ 57,544			7

8. List separately any amortization of lease expense included on page 4, line 34.  
This amount was calculated by dividing the total amount to be amortized  
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: \*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: \$ 39,180 Description: See Attached Schedule  
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	\$
13.	/2006	\$
14.	/2007	\$

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

In the box below record the amount of income your facility received training aides from other facilities.

		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 932,443	\$		\$ 932,443	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			195,049			195,049	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			1,128,205			1,128,205	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				840,074		840,074	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental					8,549	732,070		740,619	13
14	TOTAL			\$		\$ 2,264,246	\$ 1,572,144		\$ 3,836,390	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT



This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 512,965	\$ 663,931	1
2	Cash-Patient Deposits	34,422	34,422	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	3,250,442	3,250,442	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	70,475	70,475	6
7	Other Prepaid Expenses	8,120	8,120	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	747,579		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 4,624,003	\$ 4,027,390	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,627,500	13
14	Buildings, at Historical Cost		7,052,500	14
15	Leasehold Improvements, at Historical Cost	180,503	679,963	15
16	Equipment, at Historical Cost	863,875	3,023,078	16
17	Accumulated Depreciation (book methods)	(384,917)	(3,514,703)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	16,781	503,959	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 676,242	\$ 9,372,297	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 5,300,245	\$ 13,399,687	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 948,252	\$ 953,162	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	34,460	34,460	28
29	Short-Term Notes Payable		550,000	29
30	Accrued Salaries Payable	395,253	395,253	30
31	Accrued Taxes Payable (excluding real estate taxes)	19,232	19,232	31
32	Accrued Real Estate Taxes(Sch.IX-B)	2,377,500	2,377,500	32
33	Accrued Interest Payable	219	74,116	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	See Attached Schedule	413,918	619,120	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 4,188,834	\$ 5,022,843	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		11,641,202	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	See Attached Schedule			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 11,641,202	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 4,188,834	\$ 16,664,045	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,111,411	\$ (3,264,358)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 5,300,245	\$ 13,399,687	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,920,153	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,920,153	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(808,742)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (808,742)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,111,411	24 *

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

1			
	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 18,042,966	1
2	Discounts and Allowances for all Levels	(10,202,645)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 7,840,321	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	8,515,924	6
7	Oxygen	36,504	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 8,552,428	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	2,392	15
16	Rental of Facility Space		16
17	Sale of Drugs	860,908	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	206,284	19
20	Radiology and X-Ray	64,652	20
21	Other Medical Services	446,736	21
22	Laundry	2,335	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 1,583,307	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions	3,750	24
25	Interest and Other Investment Income***	12,341	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 16,091	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	4,560	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 4,560	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 17,996,707	30

2			
	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,927,006	31
32	Health Care	6,471,706	32
33	General Administration	4,628,990	33
	<b>B. Capital Expense</b>		
34	Ownership	1,707,230	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	3,937,659	35
36	Provider Participation Fee	132,858	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 18,805,449	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(808,742)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (808,742)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? not complete If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)  
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,946	2,080	\$ 66,989	\$ 32.21	1
2	Assistant Director of Nursing	1,855	2,080	82,012	39.43	2
3	Registered Nurses	55,467	59,655	2,089,550	35.03	3
4	Licensed Practical Nurses	62,233	67,292	1,475,354	21.92	4
5	Nurse Aides & Orderlies	149,185	163,317	1,723,904	10.56	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,385	1,697	32,481	19.14	9
10	Activity Assistants	7,587	8,673	104,736	12.08	10
11	Social Service Workers	11,082	11,928	275,929	23.13	11
12	Dietician					12
13	Food Service Supervisor	3,101	3,365	89,156	26.50	13
14	Head Cook					14
15	Cook Helpers/Assistants	33,176	36,128	326,563	9.04	15
16	Dishwashers					16
17	Maintenance Workers	5,234	6,178	125,239	20.27	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,178	1,213	53,685	44.26	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,986	17,898	309,471	17.29	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,047	2,347	39,999	17.04	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	714	861	41,863	48.62	33
34	TOTAL (lines 1 - 33)	352,176	384,712	\$ 6,836,931 *	\$ 17.77	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 685	01-03	35
36	Medical Director	monthly	37,118	09-03	36
37	Medical Records Consultant	43	4,128	10-03	37
38	Nurse Consultant	monthly	33,800	10-03	38
39	Pharmacist Consultant	monthly	20,086	10-03	39
40	Physical Therapy Consultant	296	14,782	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	47	2,201	11-03	44
45	Social Service Consultant	53	861	12-03	45
46	Other(specify)				46
47	Alzheimers Consultant	monthly	15,686	10-03	47
48					48
49	TOTAL (lines 35 - 48)	439	\$ 129,347		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	244	\$ 11,303	10-03	50
51	Licensed Practical Nurses	795	31,950	10-03	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	1,039	\$ 43,253		53

SEE ACCOUNTANTS' COMPILATION REPORT

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## **XIX. SUPPORT SCHEDULES**

A. Administrative Salaries			
Name	Function	%	Amount
Joanne Graf	Admin	0	\$ 53,685
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 53,685
B. Administrative - Other			
Description			Amount
Management Fees - Boulevard Healthcare Management			\$ 1,071,453
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 1,071,453
C. Professional Services			
Vendor/Payee	Type		Amount
Romanz Bornstein & Co	Accounting		\$ 357
W. Trenaman Consulting	Accounting		1,500
Frost Ruttenberg & Rothblatt	Accounting		24,913
Plante & Morgan PLLC	Accounting		3,000
AT&T	Data Processing		2,584
ADP	Data Processing		22,889
Global Exchange Services	Data Processing		291
Personnel Planners	Unemployment Consult		3,960
Various - See Attached	Legal		23,742
Year end accrual	Accounting		21,330
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 104,566
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 220,736
Unemployment Compensation Insurance			109,916
FICA Taxes			513,402
Employee Health Insurance			369,354
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Employee Welfare			12,817
Holiday Party			4,821
Disability Insurance			35,495
Employee Life Insurance			4,241
Employee Dental / Vision			21,418
401K Expense			9,525
Drug Testing			630
TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,302,355
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
			\$
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$
Advertising: Employee Recruitment			50,997
Health Care Worker Background Check (Indicate # of checks performed 187 )			2,708
Dues & Subscriptions			19,130
Licenses			16,615
Less: Public Relations Expense		(	)
Non-allowable advertising		(	)
Yellow page advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 89,450
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Seminar Expense			6,939
Entertainment Expense		(	)
TOTAL (agree to Sch. V, line 24, col. 8)			\$ 6,939

**\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT**

**\*\*See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

No
- (2)

Are there any dues to nursing home associations included on the cost report?

Yes

If YES, give association name and amount.

ICLTC \$9,196
- (3)

Did the nursing home make political contributions or payments to a political action organization?

Yes

If YES, have these costs been properly adjusted out of the cost report?

Yes
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?
- (5)

Have you properly capitalized all major repairs and equipment purchases?

Yes

What was the average life used for new equipment added during this period?

10 yrs
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 27,176

Line 10
- (7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.
- (8)

Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.
- (9)

Are you presently operating under a sublease agreement?

YES

X

NO
- (10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period.

\$ 132,858

This amount is to be recorded on line 42 of Schedule V.
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

No

If YES, attach an explanation of the allocation.

- (13)

Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

Yes
- (14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

No

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$

N/A

Has any meal income been offset against related costs?

Indicate the amount.

\$
- (16)

Travel and Transportation

a. Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

No

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$

c. What percent of all travel expense relates to transportation of nurses and patients?

None

d. Have vehicle usage logs been maintained?

N/A

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

N/A

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

Yes

g. Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such transportation during this reporting period.

\$
- (17)

Has an audit been performed by an independent certified public accounting firm?

No

Firm Name:

The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached?

If no, please explain.
- (18)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

Yes
- (19)

If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report?

Yes

Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT